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ABSTRACT

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This multimethod study investigated the effect of involuntary retirement on retirement income. Using the *General Social Survey 1994,* a secondary data analysis was carried out which examined the economic effects of retiring because of poor health. When the men and women who retired for reasons of poor health were compared to those who retired for other reasons, there was little doubt that the health retirees were disadvantaged on human capital variables, in terms of their work history, and ultimately, in their retirement income, whether personal or household. The men who retired because of ill health did not appear to benefit from government transfer payments and were less likely to receive income from a private pension or from interest and dividends. The women retirees suffered from the same disadvantages as the men, however, when they reached retirement they were more likely to rely on government transfer payments as a major source of income. Like the men, they were more likely to believe that their retirement income had gotten worse since the day they retired, and, over two-thirds believed that their financial situation had become much worse. In the multivariate analyses, however, any effect that poor health might have had on household income was offset by the benefits associated with marriage, and their own sociodemographic characteristics. This is further confirmed when personal income is considered, since marriage has the strong and *negative* influence on personal income. The interviews with the retirees indicated that retiring for reasons of poor health was seen by most people as a somewhat unpleasant transition that had long lasting and negative effects on retirement income.

1. INTRODUCTION

Understanding who retires involuntarily, for what reasons, and the ensuing consequences, are issues that have been neglected in the retirement literature. Involuntary retirees are very likely to experience economic hardship as a result of the proposed and already implemented cost-saving pension changes that many Western industrialized nations are either adopting or contemplating. For example, in the United States, raising the age of retirement will mean cuts to social security benefits for those who are forced to retire early (Ozawa and Law, 1992); in the United Kingdom and the Netherlands, tightening up the definition of disability in order to discourage the use of invalidity benefits will have negative economic repercussions for older workers forced to retire because of poor health (OECD, 1996); in Canada, the proposal to reduce the "drop-out" of 15 percent of the years with the lowest earnings from pension calculations will reduce the pensions

of women who retire to caregive (McDonald, 1996). When some of these pension changes are considered in light of the research on involuntary retirement, the implications are cause for concern.

The preliminary evidence from several countries suggests that older workers with lower socio-economic status are more vulnerable to involuntary retirement than older workers in general (McDonald, 1997; Ozawa and Law 1992). Specifically, involuntary retirees tend to have low wages prior to retirement; low pension coverage; little income from assets; and they tend to be less educated (McDonald, 1996; Ginn and Arber, 1995; Schellenberg, 1994; Ozawa and Law, 1992). After retirement, a substantial proportion of involuntary retirees report that their household income is less than adequate to meet their current needs (23 percent) and future needs (30 percent) (Schellenberg, 1994). In short, socioeconomically disadvantaged workers appear to have a high risk for involuntary retirement and subsequent financial distress in retirement.

In this research we extend the current knowledge by examining the factors associated with involuntary retirement due to poor health and its influence on retirement income. The current arguments about reduced mortality and morbidity and "compressed morbidity" tend to mask the fact that some older workers suffer ill health and are forced to retire as a result (McDonald, 1997). In 1991, 46 percent of all people aged 65 and over had disabilities, compared with 27 percent of people aged 55 to 64, and 14 percent of those aged 35 to fifty-four. How the proposed cuts to disability benefits and unemployment insurance will affect this substantial number of Canadians is an unknown, if not, a completely ignored issue. In this paper, a secondary data analysis of the *General Social Survey 1994,* is carried out which first compares those who retire for health reasons to those who retire for the reasons of caregiving, unemployment, mandatory retirement, and because of early incentive programs. Two models are then estimated. The first model examines the relative effect of poor health on retirement income. The second model assesses what factors provide a financial cushion for those forced to retired because of their poor health.

The theoretical framework guiding these analyses is the life course perspective. This perspective is chosen because it emphasizes the timing by which individuals and families make their transitions into and out of various roles in relation to the time schedules of society (Hareven, 1996). At the heart of the life course perspective is, " the synchronization of "individual time", and "historical time, and the cumulative impact of earlier life events as shaped by historical forces on subsequent events" (Hareven, 1996:31). In short, retirement for health reasons, which is an unsynchronized event, is the function of the meshing of past work history, family history, and current historical trends -- the globalization of economic activity and accelerated technological development which have plunged Canada into an historical transformation of the industrial structure of the economy (McDonald, 1996).

2. THE LITERATURE

Health, and its relationship to retirement has had a long and prominent place in the study of retirement. Poor health, as a reason for retirement, has appeared in the context of the oldest debate in the retirement literature – is it the "push" of poor health or the "pull" of a pension that leads to early retirement? The answer to this question has changed over the last 45 years depending upon the sociopolitical contingencies of the times and the discipline and/or theoretical proclivities of the researchers. In the early retirement research, health was found to be an important predictor of early retirement. In the 1980s, however, the emphasis shifted from health to pension incomes (both public and private) as the more important factor influencing early retirement (Quinn and Burkhauser, 1990; Jacobs and Kohli and Rein, 1991; Guillemard and Rein, 1993, Wise, 1993). Today, health issues are largely ignored in the retirement literature (Villani and Roberto, 1997). At best, the discussion in the literature targets the use of disability/invalidity state benefits as providing a bridge between work and early retirement, which largely ignores the actual health of the early retiree, since the implication is that workers and employers see these benefits as an expedient method for achieving early retirement whether the worker is ill or not (Guillemard, 1991).

Retiring because of poor health has been found to be one of the most frequently cited reasons for retiring (Schellenberg, 1994; Ozawa and Law, 1992; Reimers and Honig, 1989). It has also been suggested that health limits increase exits from the labour force for other reasons, even for those who do not cite health as their reason for retirement (Henretta et al., 1992). In the American literature, workers who are in poor health or who perceive themselves to be in poor health tend to retire earlier than those with above average health (Burtless, 1987). An early study of elderly Canadian men had similar findings (Breslaw and Stelcner, 1987). In a more recent US survey it was found that the most prevalent reason given for involuntary retirement was poor health, which was reported by 25 percent of the respondents (Ozawa and Law, 1992).

The British research has produced evidence contradictory to what has generally been found in other research. Early British researchers found that poor health played a major role in the retirement decision of older workers (Altmann, 1982; Parker, 1980) Later research, however, has found that health plays only a minor role in the retirement decision. Using data from the 1983 Labour Force Survey, Laczko et al. (1988) found that only 3 percent of early retirees gave ill-health as their major reason for retirement.

In Canada, illness or disability is one of the most important single reasons for early retirement. Analyses of data from the *General Social Survey 1994,* found that 27 percent of retirees cited health concerns as their primary reason for retirement (Statistics Canada, 1997). Using data from the *Survey of Aging and Independence* Schellenberg (1994), found that approximately 47 percent of involuntary retirees cited health as their reason for retiring; the number one reason cited for involuntary retirement in Canada. Using the same

data, 49 percent of the men who retired for health reasons retired involuntarily compared to 44 percent of the women.[1]

A common finding in the American, British and Canadian literature is the importance of occupational status in predicting retirement due to health. As in the case of retirement due to job displacement, lower-skilled or blue-collar employees are also more likely to retire as a result of health (Schellenberg, 1994; Henretta et al., 1992; Chirkos and Nestel, 1991; Mitchell et al, 1988). Some research suggests that blue-collar or less skilled workers tend to be engaged in employment that is physically demanding, thereby placing these workers at a greater risk of retirement should their health decline (Chirikos and Nestel, 1991; Mitchell et al., 1988). It has also been suggested that these older workers may be more severely impaired by their health problems, may not have a set of skills that are transferable to a job better suited to their abilities, or perceive the costs of unemployment as less than those of retraining or an extensive job search (Daly and Bound, 1996).

The role of gender in predicting retirement due to health is less certain and, in some instances, contradictory. Early American studies, such as that done by Palmore et al. (1985), reported that poor health was a salient factor in the retirement decision making of men only, while Midnanik et al. (1990) found the opposite.

While the research appears to overwhelmingly support the notion of poor health as the major determinant of involuntary or early retirement, there are reasons for skepticism. Most studies rely on post-retirement rationales for retirement. Therefore, some people may tend to over-estimate the role that health actually played in their retirement decision (Bazzoli, 1985). It has also been suggested that poor health is not only a more socially acceptable rationale for leaving the work force, but that it is a prerequisite for enrollment in some public and private transfer programs (Ruhm, 1990; Laczko et al., 1988). Therefore, the numbers available on those retiring for health reasons may be inflated.

Although researchers have made numerous attempts to estimate the influence of health on involuntary retirement, there has been relatively little attention paid to the economic consequences of retiring due to poor health. Indeed, more attention has been paid to the psychological outcomes attached to retiring because of poor health and even this research has been assessed as scant (Reis and Puskar Gold, 1995). Like unemployment, older workers forced to exit the labour market unexpectedly, will often have lower incomes as a result of a number of years of lost income as well as have decreased pension contributions (McGoldrick and Cooper, 1989). Although not mentioned in the literature reviewed, retirement due to health may also force the retiree to incur extra expenses related to the treatment of their particular health condition. The economic consequences of retirement due to health may be offset, at least to some degree, if the individual affected is eligible for disability benefits to bridge their income into retirement (OECD, 1995).

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[1] Authors' own analysis of the *Survey of Ageing and Independence, 1991*

Given the state of the current research, there is little that we can anticipate in our findings. At most, we would expect to find that health will have a negative effect on retirement income.

3. METHODS

The data reported here is from a larger study which investigated the effects of forced retirement for reasons of poor health, unemployment, caregiving and mandatory retirement. The study employed a multimethod approach using national data files to investigate patterns of forced retirement and in-depth interviews with a purposive sample of persons forced to retire in order to investigate the process and outcomes of involuntary retirement and its influence on retirement income.

3.1 The Secondary Data Analysis

The *1994 General Social Survey (GSS)* - Cycle 9, which addressed the issues of education, work, and retirement, was chosen for this study. The *General Social Survey* was introduced to monitor changes in the living conditions and well-being of Canadians and to provide immediate information on pressing social issues of the day (Statistics Canada, 1995). The GSS is a continuing program with a survey cycle each year. Cycle 9 of the GSS is a repeat of Cycle 4 of the GSS and differs in its focus on the quality of life after retirement and post-retirement activities. Information about education, current work and work history, unemployment, retirement and work interruptions, was collected.

The data for cycle nine were collected monthly from January 1994 to December 1994 in order to offset seasonal variations in the data collected. The target population for the GSS was all persons 15 years of age and over living in Canada, excluding those living in institutions and the Yukon and North West Territories. Data for Cycle 9 were collected using Computer Assisted Telephone Interviewing (CATI), with most of the sample being selected by Random Digit Dialing (RDD). A small supplementary sample from the *Labour Force Survey* was added to the RDD sample (Statistics Canada, 1995). The sample consisted of 11,875 respondents with 10,381 from the RDD sample and 1,495 from the Labour Force Survey. The GSS is based on a complex survey design, with stratification and multiple stages of selection, and unequal probabilities of selection of the respondents. A rescaled weight was used in the main analyses to take into account the unequal probabilities of selection, however, this weight did not take into account the stratification and clustering of the sample's design.

The subsample used here includes only those persons who worked in the labour force at some time, whether they worked full-time or part-time, and whether or not they reported themselves as retired (N=2035), unweighted. Retired was a self definition and the reasons for retirement were a "yes" or "no" response to a question asking, "Why did you retire? Your employer offered an early retirement incentive; Your health required it; Your were unemployed and couldn't find another job." An "other" category was included and,

from this, a variable describing whether or not the respondent retired to caregive was constructed. Unfortunately, the respondents were not asked if their retirement was involuntary. It is quite likely that some of the retirements were unexpected and involuntary and that the retirees had little control over the situation. It is also equally likely that some of the retirements for reasons of poor health were voluntary.

Consistent with a life course perspective, four sets of independent variables measuring demographic characteristics, past work characteristics, income characteristics and retirement behaviour are included in the analyses. All variables, except the two dependent variables, age, age squared, educational level, socioeconomic status, and household size, are categorical measures.

The sociodemographic characteristics include those factors that are known to influence retirement income (McDonald, 1996). Place of birth, a dummy variable, is used in the analysis in lieu of ethnic background because there is clear evidence that ethnicity differentially affects access to social and economic resources and, hence, retirement income (Wanner and McDonald, 1986). Marital status, and household size are indicators of consumption levels, financial resources and social support, all factors relevant to retirement income. Age is included because income generally increases with age. Formal education, like ethnicity, also affords differential access to social and economic rewards and is usually associated with larger incomes in retirement. Self-reported health and health limitations at home are included here simply to provide a comparison of health ratings by reason for retirement.

Of the work characteristics, level of education and a measure of socioeconomic status based on Blishen, Carroll & Moore (1987) are included in the analysis since these factors are known to have a very strong influence on income in retirement (McDonald, 1996). Self-employment, which is generally linked to individual control over work activities, is included because this form of employment might allow for more discretion in the transition into retirement. Whether the retiree worked full-time or part-time after retirement is considered, since this factor would definitely affect retirement income. Another important retirement variable used in the analyses included how long the respondent was retired, a variable created by subtracting the number of years retired from the respondent's age.

The income variables are the log of total personal income and household income for the year of 1993. For the purposes of this analysis, the response categories are recoded to their midpoints and then the log was taken to correct for the slight skew in the income distribution. It is important to note that the non-response rate for the GSS on the income variables was quite high -- 22 percent for personal income and 38 percent for household income. Age squared was added to the analyses because of the curvilinear relationship between age and income. Owning one's own home is used as proxy for assets and dummy variables for receipt and non receipt of a private pension, investments and other income are included in the analyses. The dummy variable for government transfer payments included a number of sources of income -- family allowance,

social assistance, employment insurance, and C/QPP so it is difficult to discern the exact source of public income.

The first analytic strategy compares those who retired for health reasons with those who retired for all other reasons on four sets of variables -- sociodemographic, work, income and retirement characteristics. Models which assess the comparative effect of retiring for health reasons on retirement income are then estimated followed by the estimation of retirement income models for only those who retired because of poor health.

3.2 The Interviews

An exploratory investigation of the effects of the different forms of forced retirement was conducted through face-to-face interviews with those affected. The qualitative exploration was carried out because there is very little, if any information, as to how obligatory retirement plays out in people's lives and how it is perceived in relation to economic independence. In fact, most recent studies in Canada, with the exception of one (CARNET, 1995), have relied on secondary data analyses to tell the Canadian retirement story.

Five groups were interviewed, but the group of interest here is those persons who retired specifically because their health was poor. The respondents in the study were recruited from Pensioners' Concerned, the Canadian Association of Pre-Retirement Planners; the AMNI Centre (Anti-racist, Multicultural and Native Centre) at the U of T; the Ontario Coalition of Services for Seniors, retired caregivers (primarily women) through the Older Women's Network and several caregiving organizations, and people with poor health through community health centres and newspaper advertisements. Purposive sampling was used to insure representation of those people identified in the secondary data analyses as the most likely to be at risk for involuntary retirement. Approximately 20 respondents were chosen for each of the five groups (n=100), in order to encompass the variety of possible involuntary retirement scenarios. The sample reported on here are 26 people who retired because of poor health.

Guided interview schedules were developed on the basis of the secondary data analyses and the advice of various senior groups. The schedule was pretested on several retirees and adjusted accordingly. The interviews focused on the respondent's experience of being forced into retirement and their interpretation of their economic security in light of this development. The role of public and private pension polices, RRSPs and government transfer payments in sustaining economic viability when forced into retirement were examined.

The respondents who retired because of poor health were one of the easiest groups to recruit for the study, mainly because this condition seemed to apply to a large number of people. In fact, more people than were required offered to participate in the study so that in the final analysis, 26 people were interviewed.

The interviews which were, on average, two hours, were transcribed. Several of the transcriptions were compared to the original tape recordings to insure accuracy. The analytical strategy was to use two coders to identify themes and relationships amongst themes. The themes were first identified from the transcripts using open coding. Axial coding was used to prepare summary sheets of the codes and then the summary sheets were used for selective coding in order to illustrate themes. The coders met on a regular basis as the analysis proceeded to compare and contrast the codes and work out relationships amongst categories.

4. FINDINGS

4.1 The Secondary Data Analyses.

Table 1 shows the percentages for the reasons for retirement by gender. For the women, the most frequently reported reasons are, wanting to retire and poor health, followed by caregiving. For the men, the most frequently reported reasons are health and personal choice, followed by mandatory retirement provisions.

TABLE 1. REASONS FOR RETIREMENT BY GENDER. GENERAL SOCIAL SURVEY - CYCLE 9, 1994.*

REASON FOR RETIREMENT	PERCENTAGES	
	WOMEN	MEN
WANTED TO RETIRE		
YES	79%	77%
NO	21%	23%

CARE GIVE		
YES	13%	1%
NO	87%	99%
UNEMPLOYMENT		
YES	8%	9%
NO	92%	91%
HEALTH		
YES	21%	23%
NO	79%	77%
EARLY INCENTIVES		
YES	Q 4%	10%
NO	96%	90%
MANDATORY RETIREMENT		
YES	11%	17%
NO	89%	83%
OTHER		
YES	5%	6%
NO	95%	94%

* Overlap between the categories has been removed.

Q Estimate is subject to high sampling variability.

TABLE 2. MEANS AND PROPORTIONS FOR SOCIODEMOGRAPHIC CHARACTERISTICS BY REASON FOR RETIREMENT (HEALTH). GENERAL SOCIAL SURVEY - CYCLE 9, 1994.

	RETIRED FOR HEALTH REASONS			
PREDETERMINED VARIABLES	MEN		WOMEN	
	NO	YES	NO	YES
AGE				
Mean	68.6	68.4	68.8	68.4
Standard deviation	7.2	6.9	7.5	3.4
BORN IN CANADA				
Yes	76.9	77.3	80.0	74.9
No	23.1	22.7	20.0	25.1
MARITAL STATUS				
Separated/Divorced	4.4*	10.1*	4.6	4.6
Widow	9.6	8.6	37.7	37.7
Single	4.5	5.3	9.1	9.1
Married	81.5	76.0	48.6	48.6
HOUSEHOLD SIZE				
Mean	2.1	1.7	1.8	1.8
Standard Deviation	.9	.7	.9	.8
LEVEL OF EDUCATION				
Mean	11.3*	10.5*	12.2*	10.5*
Standard Deviation	4.2	3.9	3.4	3.9
SES				
Mean	43.3*	36.1*	42.0*	36.9*
Standard Deviation	12.6	11.5	12.7	11.5
CLASS OF WORKER				
Self-employed	15.3*	77.9*	89.0*	90.0*
Paid	84.7	22.1	11.0	9.6
AGE RETIRED				
Mean	60.1*	59.7*	56.9	56.9
Standard Deviation	5.9	6.3	8.6	8.1
WORKED AFTER RETIRE	19.3*	5.2*	10.1*	5.0*
SOURCE OF INCOME				
Private Pension	60.2*	39.2*	38.1*	26.9*
Gov't Transfer	88.2	91.9	85.8*	92.5*
Interest	58.6*	34.4*	50.7*	32.6*
Other	Q 2.4*	Q1.4*	Q1.1	Q1.9
OWN HOME				
Yes	81.5*	71.3*	72.9*	63.1*
No	18.5	28.7	27.1	36.9
PERSONAL INCOME				
Mean	28629.9*	17955.0*	18361.25*	12969.9*
Standard Deviation	14629.0	10481.1	14629.0	7239.2

- Continued…

TABLE 2. MEANS AND PROPORTIONS FOR SOCIODEMOGRAPHIC CHARACTERISTICS BY REASON FOR RETIREMENT (HEALTH). GENERAL SOCIAL SURVEY - CYCLE 9, 1994 .....CONTINUED

	RETIRED FOR HEALTH REASONS			
PREDETERMINED VARIABLES	MEN		WOMEN	
	NO	YES	NO	YES
FAMILY INCOME				
Mean	**36164.2***	**24603.9***	**30696.1***	**23138.4***
Standard Deviation	**21068.3**	**13844.8**	**21367.2**	**16434.8**
FINANCIAL SITUATION				
Worse	**27.3***	**41.0***	**27.7***	**39.1***
Same	**51.8**	**42.4**	**51.3**	**42.2**
Better	**20.9**	**16.6**	**21.0**	**18.7**
HOW MUCH WORSE				
A Great Deal	**46.2**	**49.8**	**46.2***	**71.6***
Somewhat	**53.8**	**50.2**	**53.8**	**28.4**
HEALTH				
Poor	**5.4***	**25.0***	**4.5***	**21.5***
Fair	**14.4**	**31.4**	**13.6**	**27.3**
Good	**28.5**	**25.7**	**26.6**	**24.8**
Very Good	**29.0**	**11.5**	**33.0**	**19.5**
Excellent	**22.7**	Q **6.4**	**22.3**	Q **6.8**
ACTIVITY LIMITATION				
Yes	**25.1***	**72.7***	**31.5***	**55.9***
No	**74.9**	**27.3**	**68.5**	**44.1**
POPULATION ('000)	**1,644**		**1,135**	

***** Significant differences at the $\propto \leq .05$.
Q Estimate is subject to high sampling variability**.**

Table 2 presents the means and proportions for the four sets of characteristics by health as the reason for retirement. An examination of the means and proportions for the men indicates that the men most likely to retire for poor health are more likely to be divorced or separated, have a lower level of education, a lower socioeconomic status and are more likely to have been self-employed prior to retirement. They retired at an earlier age then those men who retired for other reasons and, as would be anticipated, they were less likely to return to work after retiring. Consistent with these observations, the men who retired due to poor health are less likely to have an income from a private pension, investments/dividends, and other income. Both groups of men are equally likely to receive a government transfer payment however it is not clear from what source. The men who retired for poor health also are less likely to own their own home, perhaps because they are less likely to be married.

The men who retired because of poor health have significantly lower personal and household incomes compared to the men who retired for other reasons – indeed, they have almost $10,000 less personal income and almost $12,000 less household income. Lest there be any doubt about the extent of the drop in income, 41 percent of the men who retired because of their poor health indicate their financial income is worse today then at the time when they retired, although there is no significant difference between the two groups of men on how much their income had worsened. As an affirmation of their poor health, 25 percent of the men who retired because of poor health rate their health as poor, compared to 5 percent of the men who retired for other reasons. A very large group of 'health retirees' report an activity limitation, namely about 73 percent compared to 25 percent report this type of limitation.

Turning to the characteristics of the women in Table 2, it is clear that the women who retire for poor health are also disadvantaged like the men. These women have lower levels of education, a lower socioeconomic status, and they are more likely to have been self-employed prior to retirement. As a result, their incomes in retirement are significantly lower than the women who retired for other reasons. Their personal incomes are about $5,000 dollars lower, while their family incomes are approximately $7,000 lower than the comparison group of retirees. These women are less likely to own their own homes, a major asset for most retirees, and they are less likely to receive income from a private pension, and from interest/dividends. Unlike the men, they are more likely to receive a government transfer payment but the nature of the data does not allow us to identify the source. The women who retire for health reasons indicate that their income has gotten worse since the day they retired and they are more likely to report that their financial situation has worsened a great deal.

The health of the women 'health retirees' is much poorer than the comparison group and, in addition, they are more likely to experience a health limitation. Consistent with their poor health, they did not return to work after retiring.

Table 3 presents two models that assess the relative impact of retiring for poor health on household and personal income. None of the reasons for retirement, net of the other sociodemographic variables, have any effect on household income for women. In fact, the characteristics that have the most effect for the women, are their marital status and their level of education and socioeconomic status. Work-related characteristics, and conditions proximate to retirement are outweighed by the marriage factor and the women's human capital. It is a common finding in the retirement literature that the potential negative effects of retirement are buffered by marriage for women (McDonald et al., 1997; McDonald, 1996).

When we consider the women's personal incomes the picture is confirmed. Marriage serves to reduce women's *personal income,* because the responsibilities of a family usually mean that women work part-time and on an irregular basis (McDonald, et al., 1997). If they are over 60 when they retire, and if they retire for mandatory reasons (which means they are in the labour force longer), their income will be enhanced. An early retirement incentive package (which less than 4 percent of the women receive) also strengthens the women's personal incomes. Wanting to retire, a personal choice, is also correlated with higher personal incomes.

In Table 3, men's household income pattern is different from the women's household income pattern. While marital status and household size are positively correlated with income, the level of men's education is the most important factor in enhancing men's household income, consistent with the bivariate analysis. Net of all other variables, poor health has a negative and significant effect on household income. Caregiving as a reason for retirement also negatively affects retirement income, but this is a rare event, as seen in Table 1, and the effect is small compared to health. When the personal incomes of men are considered, the patterns become more evident. The human capital variables operate in the men's favour, and the coefficient that has the greatest impact on retirement income, net of the other factors, is the level of education of the men. Of the retirement variables, working after retirement has a positive effect on personal income, as does an early retirement incentive package. In order of importance, unemployment, poor health and retiring to caregive have negative effects on personal income in retirement.

TABLE 3. ORDINARY LEAST SQUARES REGRESSIONS OF 1993 LOG OF HOUSEHOLD AND LOG OF PERSONAL INCOME ON DEMOGRAPHIC AND RETIREMENT CHARACTERISTICS. GENERAL SOCIAL SURVEY CYCLE 9, 1994.

	Total Household Income		**Total Personal Income**	
Characteristics	**Women**	**Men**	**Women**	**Men**
Age Squared	.000	.000	.001	-.000
	(.683)	(.311)	(.922)	(-.221)
Age	-.006	-.039	-.009	.015
	(-.776)	(-.773)	(-1.001)	(.161)
Born in Canada [a]	.102	-.016	.103	.061
	(.067)	(-.012)	(.065)	(.043)
Marital Status [a]	**.231***	**.267***	**-.367***	**.172***
	(.191)	**(.202)**	**(-.287)**	**(.114)**
Household Size	**.172***	**.081***	**-.137***	**-.098***
	(.204)	**(.112)**	**(-.214)**	**(-.140)**
Level of Education	**.042***	**.033***	**.004***	**.033***
	(.252)	**(.244)**	**(.231)**	**(.234)**
Socioeconomic Status	**.005***	**.010***	**.008***	**.011***
(Blishen)	**(.122)**	**(.227)**	**(.175)**	**(.222)**
Paid Worker [a]	.005	.019	-.005	.046

	(.027)	(.031)	(-.022)	(.029)
Own home [a]	**.189***	**.133***	.136	**.161***
	(.145)	**(.101)**	(.097)	**(.109)**
Worked After Retirement	-.128	.132	.001	**.226***
	(-.043)	(.072)	(.000)	**(.111)**
Age Retired [a]	.102	.083	**.225***	.089
	(.084)	(.066)	**(.175)**	(.066)
Mandatory Retirement [a]	.162	-.004	**.226***	-.015
	(.088)	(-.002)	**(.120)**	(-.009)
Early Incentive Package [a]	.191	.130	**.474***	**.180***
	(.058)	(.062)	**(.152)**	**(.087)**
Poor Health [a]	-.026	**-.124***	.003	**-.144***
	(-.018)	**(-.095)**	(.018)	**(-.102)**
Unemployment [a]	-.026	-.009	-.121	**-.242***
	(-.013)	(-.047)	(-.058)	**(-.121)**
Caregive [a]	.091	**-.375***	.176	-.228
	(.053)	**(-.074)**	(.093)	(-.042)
Want to Retire [a]	.148	.006	**.233***	.089
	(-.105)	(.043)	**(.152)**	(.064)
Intercept	**11.031***	**10.653***	12.096	8.606
R^2	.418	.320	.396	.320
R^2_{Adj}	.389	.305	.370	.305
Number of Cases	358	787	408	787

Note: All coefficients are unstandardized least-squares estimates; standardized coefficients are presented in parentheses.

[a] Dummy variables defined as follows: 1 if R born in Canada, 0 otherwise; 1 if R married, 0 otherwise; 1 if R is over 60, 0 otherwise; 1 if R paid, 0 if self-employed; 1 if R retired because of mandatory retirement, early incentive, unemployment, caregive, want to retire, 0 otherwise; 1 if R owns own home, 0 otherwise.

* Coefficients within the models significantly different from 0 at $\propto \leq .05$.

In Table 4, household and personal income are regressed on sources of income, controlling for sociodemographic factors for men and women who retired for health reasons. The pattern for women is consistent. The family characteristics of marital status and household size, and level of education, remain the most important variables correlated with household income in retirement. An examination of women's personal income, reveals few changes. Marital status and level of education are the two most important predictors of personal income. A private pension sustains the personal income of the women, but, only 27 percent of women who retired for health reasons received this type of income (Table 1). The findings for women are quite clear in that family factors and women's human capital are more decisive in determining retirement income.

In contrast, men's household income is more likely to be affected by family, work, and retirement factors, chiefly because men have a steady presence in the labour force. While the men's level of education and marital status are very important factors affecting household income, so too, is working after retirement, retiring after age 60 and the receipt of income from interest and dividends. The model

for personal income simply highlights these trends. Marital status, income from interest and dividends, and a private pension help to support the personal income of men who retired because their health is poor. Government transfer payments do not figure into the equation so, essentially, men must rely on their own economic resources in retirement.

To this point, we have some evidence that retiring for poor health affects the retirement income of men. The next step in the analyses is to examine how older workers actually experience retirement because of their poor health. In the next section we report on the views of the health retirees.

TABLE 4. ORDINARY LEAST SQUARES REGRESSIONS OF 1993 LOG OF HOUSEHOLD AND LOG OF PERSONAL INCOME ON DEMOGRAPHIC AND RETIREMENT CHARACTERISTICS FOR HEALTH RETIREES. GENERAL SOCIAL SURVEY CYCLE 9, 1994.

	Total Household Income		**Total Personal Income**	
Characteristics	**Women**	**Men**	**Men**	**Women**
Age Squared	-.001	-.002	**-.000***	.000
	(-.528)	(-.359)	**(-1.713)**	(.417)
Age	.004	.004	**.117***	-.039
	(.566)	(.050)	**(1.542)**	(-.537)
Born in Canada [a]	-.005	.003	-.131	-.014
	(-.028)	(.021)	(-.102)	(-.012)
Marital Status [a]	**.317***	**.564***	**.201***	**-.385***
	(.272)	**(.443)**	**(.169)**	**(-.379)**
Household Size	**.289***	.002	-.027	.017
	(.327)	(.022)	(-.048)	(.029)
Level of Education	**.003***	**.003***	.009	**.028***
	(.197)	**(.199)**	(.082)	**(.219)**
Worked After Retirement	-.008	**.341***	.207	-.067
	(-.021)	**(.154)**	(.100)	(-.018)
Age Retired [a]	.005	**.181***	.111	.073
	(.043)	**(.158)**	(.105)	(.072)
Own home [a]	.009	.002	.120	.111
	(.082)	(.012)	(.104)	(.107)
Interest	.132	**.308***	**.314***	.066
	(.109)	**(.265)**	**(.289)**	(.062)
Private Pension	.155	.002	**.143***	**.218***
	(.122)	(.018)	**(.136)**	**(.199)**
Gov't Transfer Payments	.008	.121	.124	.261
	(-.038)	(.058)	(.069)	(.134)

Intercept	7.711*	9.665*	5.742*	10.377*
R^2	.492	.521	.354	.344
R^2_{Adj}	.433	.484	.315	.281
Number of Cases	115	166	210	137

Note: All coefficients are unstandardized least-squares estimates; standardized coefficients are presented in parentheses.

[a] Dummy variables defined as follows: 1 if R born in Canada, 0 otherwise; 1 if R married, 0 otherwise; 1 if R 1 if R owns own home, 0 otherwise; 1 if R receives income from government transfer, interest, private pension, 0 otherwise.

* Coefficients within the models significantly different from 0 at $\propto \leq .05$

4.2 THE RETIREES SPEAK

4.2.1 Respondent Profile

Although a convenience sample was employed, the 17 women and 9 men that agreed to be interviewed were a diverse group. The length of time the individuals had been retired ranged from several months to approximately 18 years. The health problems that led the individuals into retirement varied greatly, including such things as arthritis, cancer, work-related injuries, respiratory ailments, Parkinsons Disease and mental health problems. The average age of the respondents was 62, which was about four years younger than the respondents in the national sample. Although a few of those interviewed had substantial retirement incomes, the majority of respondents (64%) had annual incomes under $20,000, with 36% having annual incomes under $15,000. These incomes are surprisingly consistent with the GSS sample.

The marital status of those interviewed varied greatly, as 39% were married, 38% were either separated or divorced, 19% were single, and 4% were widowed. A large percentage of the sample were renters (54%) and had at least completed high school or better (69%). Six of the respondents had also immigrated to Canada at some point in their lives. These respondents came from the United Kingdom, Trinidad, Jamaica, Portugal and Spain. The following themes were identified based on an analysis of the 26 transcripts by two coders.

4.2.2 The Retirement Decision

The literature finds that health problems place individuals at a greater risk of leaving the work force prematurely. (Schellenberg, 1994; Reimers and Honig, 1989). In Canada, illness or disability is one of the most important single reasons for early retirement. There is, however, no extant research which details how

people move from the labour force into retirement as their health fails. In the reports of the respondents, the factors relating to health that influenced the decision to retire fell into two main areas: the relationship between work and health and the degree of employer support and accommodation.

The Relationship Between Work & Health

A dynamic relationship between individual health issues and workplace demands emerged from the interviews. All of the respondents identified work as having a definite negative impact upon their health; either in creating their individual health problems or by exacerbating pre-existing health conditions. Conversely, they all felt that their health had a negative impact upon their ability to carry out their work-related duties and assignments.

As would be expected, the stresses and strains, both physical and emotional, experienced by many of the individuals as a result of workplace demands, were major factors influencing the decision to retire. Increasingly, many found that their work or workplace environments had a negative impact upon their heath and well-being. The retirees were explicit about these effects:

> R: "…the main problem was I had a tremor in my left hand and the work that I was doing required me to be on the computer quite a lot and so it was difficult…plus the other symptom that I had was a slowness in movement so, you know, not eating properly due to the fact that we had to make deadlines or, you know, scoffing a sandwich when I was on the phone at lunch time instead of going out for a walk or having a rest, started to tell on me. So there was the fatigue and there was the slowness, not being able to get the work done, you know, in the given time, so I had to work longer hours or re-do work and that was, that was bothering me."

> R: "I had to be alert and …sometimes it was too much and I'd get very tired and anxious and my body would go numb and I'd start to feel little symptoms of blurred vision and fatigue coming on. So then I tried to slow down a bit, but then I realize that sometimes when you're in the workplace you can't slow down, you gotta take on the clients and students you're given, you know. It's not easy."

> R: "…the stress of the job was getting so incredible that I knew it was making my health worse, it wasn't, okay, you've got a health problem and you need six months off to get over that, because auto-immune diseases are very much affected by stress…"

R: “Well, I was fatigued both physically and mentally by the time I left the workplace, I was shattered.”

At the same time, many respondents realized that their health problems were interfering with their abilities to carry out and complete their work assignments. This realization was also a major determining factor in the retirement decision. Hindrances to work included absenteeism and missed days due to illness and to attend medical appointments, a slowing in their abilities to carry out work-related duties, and an increasing inability to carry out certain work functions. As several respondents noted:

R: “ You know, it would take me longer to do things because you were fighting the psyche trying to, you know, keep yourself calm, you know, and so some, get your work done and then know, trying to do things and, you know, not shake. This is a big thing. ‘Cause I got to the point I used to always hold on to my arm, cuff my arm under my other arm…just to keep the tremor in control…and that, you know, I used to type fairly proficiently and then losing the fine, fine control of the hand was frustrating too.”

R: “…I used to take the days off, now like I’ll go to work and the knee’s sore and I’ll call and say, I don’t think I can finish the day, you know, and they would say, go home, and send somebody to replace me.”

R: “I was only allowed three pills per day, and so it was taken every 8 hours, and half way through the shift I’d be ready to go back to bed and I felt I was losing ground. And I didn’t know who…who I was hurting most - the patients because I wasn’t able to do what I’d like to, or me…And it got to the point where I thought, you know, it’s either retirement because of my health or get fired.”

The Degree of Employer Support and Accommodation

For many, the support, or lack of support, received from employers and work colleagues played a role in the timing of their exit from the labour force. Several people felt that neither their employers not their colleagues fully understood their health situations or needs which, in turn, complicated their ability to balance their work and health demands. As these individuals commented:

R: …I thought the colleagues, the co-workers were not very supportive. They couldn't understand - Well my mother has arthritis and she still works full-time, what's wrong with you?"

R: "…both the rehab officer and myself had approached my director about job sharing, working at home, and she was completely against all that…there was no flexibility at all."

R: "Well, if you got sick, too bad…either you do your job or you go home and don't come back until you can do it…Apparently, according to the contract they have with the union, if your health starts getting like mine, you're supposed to be able to move to lighter duties and stuff. But they…I found that ***, like I mean, as far as they were concerned, if you can't do the job, it's like goodbye."

R: "…when I find out that I couldn't go around anymore, I asked them, I said do you guys have anything in the office I could do like even stuff you know like… any filing. They said no, they don't have any sit down job."

R: "When the job started getting really, really busy I did tell my boss, I said we really need an assistant in here…as the job got busier and busier and I would vocalize a need for a little bit of extra help…I think if that would have happened, perhaps I wouldn't have got quite as ill as I did…"

Some of the individuals attributed this lack of understanding either to ignorance about their particular health problem or the "invisibility" of their disabilities:

R: "I guess one of the other frustrations about it is that if anyone saw we walking down street or just saw me sitting, I don't think that they would know really that there's much of a problem…"

R: "…you know, if you're retiring because you're ill, it's like…if they can't see the illness, if they can't see a wheelchair or a brace, it's like, "Well, you can't be that bad". Do you know what I mean?"

Others indicated that their employers were quite empathetic to their health problems and tried to support them. While this support ultimately did not prevent them from leaving the work force, it certainly allowed several of them to remain in the labour force for an extended period of time. At the very least, provided them with a greater sense of control over their exit from the labour force. As several respondents noted:

> R: "Luckily I had a department, a couple of good assistants and I would just come in the morning, shut my office door, and say listen ***, you really have to handle things; I'm just not hacking it, so he would, and he was an excellent fellow. And I had two assistants…and they held it up for a couple of years…"

> R: "…we eventually got me a headset for the phone which helped. And I guess because of that I was able to continue working longer…"

> R: "She said, "Do whatever you have to do for your health and don't worry about your job, don't worry about your pay, don't worry about anything…we will do anything we can to support you…"

Others felt that their employers might have been willing to accommodate their health issues, but that this was something that they did not pursue fully. As two of the women commented:

> R: "…I talked about that with my boss briefly, but we never really got to the point of doing anything about it. We talked about moving my computer home and maybe doing some work and everything, but I think it really turned out that during that year…I really was too unpredictable how I would feel and how I could perform and so we never really did it."

> R: "…he said well, you know, take what time you need and give us a call and maybe we can have short time contract work for you or something, but since then I, I, you know, short term contract work in our place would mean those long hours again.

4.2.3 The Blurred Path to Retirement

An emerging theme in the retirement literature is the blurring of the transition from work to retirement. Older adults are entering, exiting and re-entering the work force at varying points during the latter part of the occupational life cycle, for varying and often compounding reasons. Several of our respondents

exemplify these new trends in retirement. While health demands were the major influences behind retirement for these people, they certainly were not the only factors that led these individuals into retirement. Other factors such as caregiving, dissatisfaction with employment, and unemployment figured into the retirement decision:

> R: "I just wanted to get out…and my mother kept falling so we wanted to spend some time with her…I would have retired earlier if I could, but I wanted to get the pension and they were kind enough to give it to me…but this was on health grounds."

> R: "I broke my wrist in my right hand and it took a while to heal up...they wanted me to come back and work after my hand healed up. But I didn't get along with some of the workers there."

> R: "…I stopped in September, I applied for unemployment and then, November I had a heart attack…therefore, between times what I had was this experiencing the futility of looking for a job and then I had a heart attack which put me in bed and surgery later on in the same year, and that was the end of it…"

Although poor health was the major factor influencing the forced retirement of all these individuals, it was clearly intertwined with other factors such as caregiving demands, dissatisfaction with work and unemployment. Health may have been cited as the main factor determining retirement because, as the earlier research suggests, poor health is not only a more socially acceptable rationale for leaving the work force, but it is a prerequisite for enrollment in some public and private transfer programs (Ruhm, 1990; Laczko et al., 1988). These complexities in the transition from work to retirement, as evidenced here, are difficult to track in secondary data analysis and frequently are overlooked as a result.

4.2.4 Retirement Planning

A large majority of the individuals we interviewed, particularly the women, had done little, if any, formal financial planning for their retirement. At least three main factors were identified as having influenced retirement planning: the timing and duration of their illness, the lack of financial resources for planning, and an inattention to the future. A fourth factor was identified for many of the women we spoke with -- a reliance on their spouse to plan for retirement and the belief that the spouse's retirement income would be sufficient for their needs.

Timing and Duration of Illness

Both the timing and duration of illness or health impairment had an impact upon the individual's ability to plan for retirement. In a couple of cases, the onset of illness or health impairment occurred suddenly at a younger age, thereby preventing the individual from making any advanced retirement plans. As expressed by two respondents:

> R: "No, there was no planning. Nothing was planned, everything was so sudden. You see everything was cut short by the heart attack and then suddenly you find yourself in an uncontrollable mood; you don't know how to think properly and then it was too late to plan. So your planning is from now on."

> R: "…actually, I had $8,000 and everything paid for you know. It was important that I save everything the next few years and I didn't intend to retire the day I went out the door, no absolutely not. It was a surprise to me that the whole thing developed and evolved as a surprise."

It was anticipated that those who were experiencing chronic conditions would have some foresight and would have planned for their retirement to some degree. Surprisingly, a large majority of these individuals did not make plans for their retirement. Reasons for this varied and, as previously identified, included: a lack of financial resources, individual perspectives on planning and, for many women, reliance upon their spouse's retirement plans.

The Lack of Financial Resources

Many of the lower income individuals (usually women) that we interviewed felt that they just didn't have enough money to do any type of planning for retirement. The money that they had earned during their working years went to pay for things such as basic household expenses like food and repairs as well as to support children. Many of the poorer individuals were quite clear about the immediacy of their needs that militated against long-term planning:

> R: "…actually, I never thought I would reach 65…if I reached 65 I would survive the best on what we've got, having a roof with a little pension of course…there was nothing else because I had kids…there was not much money that you could put aside for that intention of retirement, no there wasn't…"

R: "…I had too many other things to contend with, like it was more important that my children went to school having a breakfast and a lunch than it did for me to worry about something 40 years down the line when I'd be 65. The present day things were the things I had to concentrate on."

Inattention to the Future

Others indicated that advanced planning, not just for retirement -- but advanced planning in general -- was something that they did not do. They could not think about the future because they were caught up in the present. The future crept up on them and caught them unprepared. When asked why they hadn't planned for retirement, several individuals explained:

R: "…it was so far in the future. It was always just so far in the future. I mean, I wish now that we had, But I never did."

R: "…I don't look too much for the future. I enjoy my life."

R: "You didn't think much about those things, you know, retirement or anything like that, because you were so young…"

R: "I never saved much…I figured what I went through when I was twenty years old and they said I wasn't going to live…I had trouble with my body at times and I though, well I'm not going to live long anyway so…"

Reliance on Spouse's Planning

For several women, planning for retirement was not an image they could apply to themselves, but rather one they applied to their husbands. A few of the women had expected that the retirement incomes generated by their husbands would be shared. Marital breakdown in later life, however, eradicated this possibility for them. In their own words, the women said:

R: "…I didn't worry about future security, you know, and I certainly assumed that my future security would be tied up to his. ..my view was we were a team…but that's the old way of looking at things. It leaves the woman totally, totally vulnerable."

R: "…because I was married and you know, we were living in a house, and you know, you just kind of assume that that's all going to look after itself when you've got a husband who's working and making pretty good money and a retirement plan."

R: "…No, well they had a retirement pension plan; they also had a health plan but I didn't, because I was married to a school teacher; shows you how foolish I was."

The people who did plan for retirement employed a wide range of different strategies to assist them. These individuals were small in numbers and generally were wealthier and had long-term, stable employment. Strategies included such things as putting money away in RRSP's, GIC's, and other investments, building private pensions if they were eligible, purchasing insurance policies and paying down mortgages as quickly as possible. For example:

R: "…well, as you get older these things come into your mind…you know, get some money put away into RRSP's or something like that, take advantage of the tax breaks and so on and so forth…"

4.2.5 The Financial Impact on Retirement Due to Poor Health

The most immediate and obvious consequences of unexpected retirement are lost earnings as well as decreased pension benefits. Retiring due to poor health had a financial impact on almost every individual that was interviewed in the study. The respondents outlined how the drop in income affected them:

R: "Oh with my savings, you know, I went through my chequing account and my savings account, then my Canada Savings Bonds and now I'm taking RRSP's…"

R: "I had to cut back; I had to really had to think twice about buying things now even like, even sometimes like toiletry products, you know…it depends you know, if it's getting close to the end of my cheque, you know what I mean…"

R: "I'm just barely making, well I, right now, to be quite frank with you, I only have $150 left over after I pay my…my expenses to live here and that's not a whole lot of money then to put gas in your car, and food in your stomach…"

R: "I had all my working years paid my bills, and I had always been able to keep up with them and all the rest of it and then suddenly to be…you know, have the…Revenue Canada force me into bankruptcy…"

There were two main factors, both in the short and long-term, that influenced the financial well-being of the respondents. These were previous labour force participation and the costs of managing ill health.

Employment Histories

Life course theorists suggest that work over the life span lays the cornerstone of the foundation for economic well-being in old age (Jackson, Antonucci and Gibson, 1990). As was the case for many of the retirees in the study, previous labour force participation of the lower income retirees, particularly the women, had a significant impact upon their retirement income. The majority of these individuals had multiple, short-term jobs, worked part-time, and had interrupted work histories. Many of the women had been out of the labour force at varying points throughout their life due to familial responsibilities such as raising children. These labour force participation practices served to reduce the benefits they derived from both the public and private pension systems. The labour force participation of the women interviewed deserves further attention, given the large number of women whose retirement income was negatively affected by it.

Many of the women we interviewed indicated that they had left employment or were limited in their employment opportunities early on in their careers, either because they married and/or chose to start of family. As two women observed:

R: "…I worked until I had to leave ***. I didn't just quit as soon as I got married. I worked until I had to leave…because I was pregnant…I don't think that that was a policy. I think it was a decision that was made by 95% of the women who were working there at that time."

R: "…I would not leave my children with baby-sitters, because I figured they were mine and they were up to me to raise…"

Several women also indicated that they had left work or limited their hours of employment in order to comply with the wishes of their spouse. The women noted:

R: "My husband had a good job, and he made more…working Saturdays overtime than what employers were offering me for a whole week at that particular economic time…And he said, "Why should you go out and work five days a week, use the car, gas, all this nonsense, when I can make more in one day at *** on overtime"?

R: "I wanted to go back to work after my second one was born. But my husband said, "No wife of mine is ever going to work. I'm the bread winner period".

The financial implications of the employment histories of women from this generation are not encouraging. Many older women today are financially distressed because they lacked the opportunity for employment that offered good wages and benefits such as a pension in retirement. For example, many of the women, especially the low-income or lower-middle class women we interviewed, were concentrated in the services sector in retail trade and business services where they worked part-time and where there is little hope of a job-related pension. Their part-time work patterns also served to decrease the benefits these women would receive from the public system (C/QPP). Their low incomes further served to reduce the amount of money that they might have put into savings and investment vehicles such as RRSP's, and GIC's that would have provided additional income in their later years, especially upon becoming incapacitated in their ability to work due to health. Most of these findings are confirmed in the secondary data analyses reported above, where it was clear that family history transcended work history in influencing income in retirement.

For the most part, the men interviewed benefited in retirement from their long-term, stable employment in sectors of the economy that provided them with private pensions and work-related benefits. These labour force patterns served as a buffer against the negative financial consequences of forced retirement due to health.

The labour force participation of immigrants also warrants special focus. Depending upon what age people immigrated to Canada, many immigrants are not eligible for full benefits from either the C/QPP or the OAS. As one gentleman commented:

R: "...we don't qualify for the full amount. That's where the impact is, to work for 40 years, it means you have to come here when you're just 18 or 20 years old…Any person in their 30's or 40's, as an immigrant at that age will find it difficult to qualify for 40 years of CPP…"

Financial Costs Associated with Illness

The monetary costs associated with ill health were identified as financial stressors for many of the retirees, particularly the lower income retirees. While many products and medications are provided through the social welfare system or through private plans at little or no cost, there are number of items that are not covered, or a ceiling is placed on the amount covered. This was especially true for a large number of the people we interviewed that were not yet eligible for the seniors' drug program. As a result, the individuals found themselves having to pay for such things as medical supplies and some medications:

R: "…most of my drugs are paid out, but I also have some allergies and you don't, you need to pay for them, and they're expensive."

R: "…it would have been really hard trying to manage with the CPP and the long-term disability, because my supplies, my bags and the flanges and the medication came to $500 a month…and that's why I had applied for the hospital pension, because I figured I needed that cheque to cover the costs of the supplies."

R: "I needed some heavy duty antibiotics and they're, they're fairly costly and plus the other medication that I have is fairly costly, so altogether, I'm, I would be spending about $1200 a month on drugs, 'cause I don't have a drug plan…"

4.2.6 Perceptions of Income

While no one in the convenience sample stated they were pleased with their retirement incomes, most adopted a view that they would make do and "get by" with what they had, although they were clearly struggling. The majority of the individuals perceived their incomes to adequately meet their most fundamental needs. This phenomenon, of assessing income as adequate despite the fact that it is low, has been well documented in the research on older persons (Goetting et al., 1996). As the research suggests, the views may represent a cohort effect, since many members of this particular age have come from families of very modest means, or experienced very lean years at the beginning of their lives:

R: "…I was born in the 20's, I grew up in the hungry 30's, I went through the war, I grew up one of six and it was just ingrained in me that I had to look out for myself…"

R: "…I'm finally at the point where I feel comfortable and I feel like I've got it under control. It's not what I'd like it to be, but at least I've got it under control and I feel like I have a few options.

R: "With the little I was getting, the little I'm getting, I do the best I can with that. Like say, wait a minute, I have to survive on this, I had to do what I had to do with this. And I'm quite happy saying well, okay, I know I can't go here because I don't have it, I'm not going, I can't spend that dollar 'cause I need it for tomorrow, I'm not going. I feel happy that I manage it this way, you know…the little I'm getting, I'm surviving. Sure it's not easy, but I'm doing it."

Although some of the people expressed satisfaction with their current income levels, however diminished, there were also a number of people who were quite troubled by their current financial situation. The views of these people probably predominate since they prevailed in the secondary data analysis of the GSS. It is important to note their comments because they probably offer a more realistic evaluation of life for many of the people who retired due to poor health:

> R: "…I'm pretty frustrated at this point and I'm very worried financially, because this is a very expensive disease…because you don't get better, I mean it's not just buying grab bars for your bathroom so you can get out of the tub…"

> R: "… I feel inadequate in the way I'm providing for my wife…and paying 64% of my income for housing, and that leaves very little for groceries. I don't smoke, I don't drink and the little that I have left is the car, which I can't afford with the price of gasoline and insurance and, as long as my car don't need any major repair, I'm able to drive it, but the minute something major comes up I'll have to give that up. It becomes a stress, not intentionally, but emotionally, and in some cases with my wife. We are under stress because of all the nonsense that's connected with this…"

4.2.7 Financial Strategies

Regardless of whether the respondents reported satisfaction or dissatisfaction with their financial situations, virtually all of them indicated that they have had to develop strategies in order to deal with the changes in their income:

> R: "When we're shopping, we always make sure we look for the bargains, the best buys really…I'm very careful with paying my bills. I'd rather pay my bills and walk in a shoe with a hole in the foot, in the sole. I wouldn't go and buy a new pair of shoes…I will wear another shoe, that's what my mother taught me."

> R: "…our option is to sell our bigger house, this house, when the kids leave and get a bungalow, which would be sufficient for the two of us. That's one way, and then you'd have a bit left over to reinvest for income."

R: "…I can manage, I can manage. I'm a good manager, a very good manager…I shop around where things are on special because I basically know what I want to pay for…I can but bread 35 cents a loaf from the bake shop when it is a day old and you never eat a whole loaf of bread in one day when you are alone, so what's the difference…"

Overall, most individuals did without something or foresaw having to make some tough choices in the near future:

R: "…I don't get a screen door on there, I don't, you know, do anything else, don't buy any clothes, cut way back on presents and things. It's very, very tight…"

R: "Again, unless the unexpected, if the worst comes to worse, I have to sell maybe and rent, that is going to be the final decision. If I have to do that, I will do that."

R: "I know one thing that if things don't change real soon, I won't have any medication and what the repercussions will be for me from that is, could be my health and could be my demise, but when it comes to the choice between medication or groceries, I'll buy the groceries."

The ability to project their financial needs or financial security into the future was a difficult exercise for many of those interviewed. They felt this would depend on a number of factors, particularly changes in their health, that were both beyond their control or impossible to predict.

4.2.8 The Importance of Social Security and Income Replacement Programs

The importance of social security programs was made evident throughout the interviews. Programs such as Medicare, subsidized housing and income replacement programs, including social assistance, CPP Disability, regular C/QPP benefits, and the Old Age Security Pension, were the factors behind the economic security of the majority of the respondents. While the income replacement programs were only able to provide some individuals with a small portion of their pre-retirement earnings, for the majority, these benefits made up the largest part of their post-retirement income. In fact, if it were not for these programs, many more of our respondents would have fallen well below the poverty line. As one respondent commented:

R: "…I can stretch my money simply because I live in subsidized housing - without subsidized housing I could not exist."

Although the value and necessity of these programs is evident, the respondents did identify significant shortcomings with these programs, specifically the CPP Disability Program and Social Assistance. The three major themes that emerged included: eligibility requirements, waiting periods for processing of applications and receipt of benefits, and the disincentives to work built into these programs.

Eligibility Requirements

A number of the people interviewed expressed extreme frustration with the requirements that had to be met in order to qualify for some of the income replacement programs. A requirement of particular concern regarding Social Assistance was the need to dispose of one's financial assets. As two respondents noted:

> R: "I've been living on my savings and it's funny, I'm a poor person, but I'm too rich to apply for welfare 'cause you have, if you have $3500 or less, apply for welfare…well, at this point, I've still got slightly more than that…but you know, this was the money that I came to save so that I could have a good 65, you know, and now I'm spending it. I'm hoping that the government benefits will come through, the ones that are under appeal…"

> R: "…I had a little bit of money put aside. I used to put some aside you know, cause I…cause you think of a rainy day. But I had to use that all up before I could get assistance."

Another source of frustration regarding eligibility was meeting the criteria of "disabled" under these programs:

> R: "Sometimes I sit down and cry…I don't know if I am coming, I am going. My doctor put me on disability, they denied it. Because, like what they're saying is like I still have the ability to go out and work…if I could work, I would be out there working…"

Waiting Periods

The amount of time required to process an application for the CPP Disability Program was another major source of frustration for many of the individuals. People found themselves waiting anywhere from six to nine months to find out whether they were even eligible to receive benefits. A number of the respondents were quite vocal about this issue:

R: "…if the government wants to be careful I can understand that, but why they have to take six to nine months to be careful…people have chronic diseases, they don't get better in six to nine months, they only get worse…so it seems to me that there should be some sort of a priority system there or they should have enough people to review these cases in a timely fashion. I don't consider nine months timely."

Disincentives to Work

A final source of frustration for many of those interviewed was the restriction placed on them with regard to paid employment. In order to receive benefits, one had to give up work completely. Many of those interviewed felt that they could have remained working in some capacity, but this was not an option under these programs:

R: "…when you are on Canada Pension they don't want you to work for anything anyway…I said "What can I, if I'm on disability, what can I make?" He said, "Not a thin dime."

R: "So it's unfortunate that the system isn't set up, and this is where I would love to be able to stand on a podium and have everybody in *** and politicians hear me is that they need to take a look at the various kinds of illness, from the real medical standpoint, and say, okay, you have "x" illness, what are your boundaries around working, what can you do, how can you contribute, how can you be useful because the way the system is now, it's so black and white, either you can go to work or you can not. Like Canada Pension, you can't earn 5 cents and yet the money that they give you, it's not really sufficient to live on. So then you wind up having to go on subsidized housing so they're really supporting you totally…"

Private Disability Insurance

For a minority of the people we interviewed, private disability insurance programs bridged the financial gap from work to retirement. In several instances, they augmented the benefits that were received from other sources. As one man said:

R: "I can remember the day it was offered to me and I thought, what the hell do I need this for, and then for some reason I took it, which, you know, was a big blessing… because we would have been in bad straits if, you know, I didn't have it. So between, you know the long term disability insurance and Canada Pension Disability, that's what we're living on."

While these programs were beneficial in maintaining or replacing income, like their publicly sponsored counterparts, they did have their limitations, specifically with regard to accessibility, eligibility and disincentives to work:

> R: "There's another problem too. I had, I had private health insurance, and it was disability insurance, and I applied for a disability insurance benefit and they contested it…they say that I probably had prior knowledge of my disease, which I didn't…"

> R: "…they refuse to accept the definition of disability as, as written by my doctor…My doctor says that I'm being taken down the garden path. That it's absolutely terrible and he did work for an insurance company himself…"

The major limitation of these types of programs was their lack of accessibility to lower-income earners. Based on the individuals we spoke with, only those in the upper income categories or those who worked for employers who sponsored these types of programs were eligible. Like its public counterpart, private disability insurance is also a disincentive to continuance in the labour force. Again, the stipulation built into the receipt of many of these benefits is that the individual not work for pay in any capacity.

4.2.9 The Retirees' Fears

A common issue that many of respondents identified as potentially affecting their income negatively was the need for institutional care. The fact that these individuals all have significant and often degenerative health problems makes this a valid concern for these people:

> R: "…if I get the government pension, then I should be, the disability pension, then I should be okay provided there's nothing major. Now if I had to go into a private nursing home, it would be different. I mean assuming that I can still remain reasonably independent, not living in a nursing home, then I should be okay."

> R: "My greatest fear is that somebody will have to look after me…"

A number of respondents also expressed doubts as to whether their incomes would continue to meet their needs. This is a legitimate concern, as many of the lower-income people are living on fixed incomes. This may also be a concern for the upper income earners, as many of them rely on income generated from investments which are subject to fluctuations in the marketplace. Several individuals voiced their concerns:

> R: "The pension is around $300…it isn't much. My rent…my rent is close to $700 now a month and then I have…TV's gone up…telephone's gone up…it seems to…I don't know…going up forever. And food is going up…"

> R: "I don't know what's going to happen when I do turn 65…I think that considering the way things are going, that the income…things are going to be really tight the way things are going…because…you know, everything keeps going up…"

Another common concern was the continuation of social security programs, specifically health care and pension programs. When asked to project their economic security in the years to come, the retirees made reference to the recent social policy debates concerning the reform of many social security programs such as the C/QPP, OAS and health care. Their sense of uncertainty and the unsettling effects on their lives is clear:

> R: "You don't know what's going to happen…pension, prescriptions and drug plans and the cutbacks at the hospitals…"

> R: "… you don't know, is the Old Age Pension still going to be around, you know, another ten years…so like there's, you know, a bit of pressure and you've got to look after yourself."

> R: "If you rely on the government, I mean its pathetic the pension we get. I get CPP and the Old Age Security and all this, but it's a joke you know…One can survive on it, but who the hell wants to survive…"

5. Summary Conclusions

This research provides initial evidence that retiring because of poor health has a significant and negative effect on retirement income, especially for men. Although the national data from the GSS are correlational and retrospective, and the health retirees represent a convenience sample drawn from community agencies, there is considerable agreement between the two different data bases, and within the data bases, to suggest that retirement due to ill health can cause economic stress in retirement. When the men and women

who retired for reasons of poor health are compared to those who retired for other reasons, there is little doubt that the health retirees are disadvantaged on human capital variables, in terms of their work history, and ultimately, in their retirement income, whether personal or household. The men who retired because of ill health did not appear to benefit from government transfer payments and were less likely to receive income from a private pension or from interest and dividends.

In the national data file, there is a certain consistency in the reports of the male retirees since they are more likely to report that their health is poorer and that their income worsened from the time they retired. In the multivariate analyses, retirement due to poor health has a significant and negative impact on both household and personal income, although unemployment has a slightly stronger effect. When the factors that might strengthen retirement income are considered, it is clear that the men must rely on their own financial resources in retirement, such as private pensions, or returning to the labour force.

The women retirees suffer from the same disadvantages as the men, however, when they reach retirement they are more likely to rely on government transfer payments as a major source of income. Like the men, they are more likely to believe that their retirement income has gotten worse since the day they retired, and, over two-thirds believe that their financial situation has become much worse. In the multivariate analyses, however, it is clear that any effect that poor health might have on household income is offset by the benefits associated with marriage, and their own sociodemographic characteristics. This is further confirmed when personal income is considered, since marriage has a strong and *negative* influence on personal income.

The findings from the national survey were supported in the interviews. Overall, retiring for reasons of poor health was seen by most people as a somewhat unpleasant transition that had long lasting effects on retirement income. The retirement decision was not straightforward and was affected by the interplay between the retirees deteriorating health, which was sometimes exacerbated by the work, and the recognition that their poor health affected the quality of their work. Whether or not their employer understood and accommodated their health needs made a difference in the timing of their retirement. In addition, the health factor was entangled with other factors, to the extent that a number of transitions occurred together. In terms of retirement planning, few actually had engaged in this activity. The rapid onset of a health problem militated against planning, as did a lower socioeconomic status, and a disregard for the future which arrived sooner than expected. Many of the women in the sample believed that their spouses would do the retirement planning and overlooked the possibility that a substantial number of them would be separated or divorced in later life.

For all the members of the convenience sample, retirement due to poor health negatively influenced their income, even if they considered themselves to be well-off and had planned for their retirement. Most had to utilize some type of strategy to survive financially which ranged from selling their home, to going on welfare, to simply trying to manage better. Many members of the sample saw their income as barely adequate, a finding similar to the responses in the national data set. The costs of being ill also added to their economic

woes. Contrary to the findings from the national study, the convenience sample indicated that government transfer payments were key to sustaining them in retirement, probably because the majority were women. They identified three major problems with these programs, namely shifting eligibility requirements, lengthy waiting periods, and disincentives to work. One of their greatest fears was the continued viability of the Canadian pension system and the health care system.

Although the data present a precursory picture of health retirees, there is enough evidence to suggest that there are several difficulties with the transition into retirement for reasons of ill health. The first major difficulty is that this group of retirees has been largely ignored by researchers, a serious matter, since approximately one in four Canadians retire for health reasons. As a result, policy makers tend to overlook this substantial group of Canadians, and, in fact, have recommended changes to the public pension system that would be detrimental to the economic well-being of the retirees. For example, raising the age of retirement, or reducing the size of disability benefits would be short-sighted for this group. The constant whittling away of unemployment benefits and social assistance is equally myopic. The second problem is that the public and private pension systems do not protect the income of the retirees against the vagaries of their inferior health, nor do they take into account a lifetime of disadvantage. Workers who retire for poor health tend to be handicapped across the life course because of lower levels of education and training, unstable employment histories, and lower wages. At retirement they must depend on their own resources, not an easy task, according to the retirees in this study.

BIBLIOGRAPHY

Altman, R. (1982). The incomes of the early retired. *Journal of Social Policy*, 11(3), 355-364.

Bazzoli, G.J. (1985). The Early Retirement Decision: New Empirical Evidence on the Influence of Health. *The Journal of Human Resources*, 20(2), 214-234.

Blishen, B.R., Carroll, W.K., Moore, C. (1987). The 1981 Socioeconomic Index for Occupations in Canada. *Canadian Review of Sociology and Anthropology.* 24(4): 465-488.

Breslaw, J.A., & Stelcner, M. (1987). The Effects of Health on the Labor Force Behavior of Elderly Canadian Men. *Journal of Human Resources*, 22(4), 490-517.

Burtless, G. (1987). Occupational Effects on the Health and Work Capacity of Older Men. in G. Burtless (ed.), *Work, Health, and Income among the Elderly*. (pp. 103-150). Washington, DC: The Brookings Institution.

CARNET (1995). *Issues of an Aging Workforce: A Case Study of Sun Life Assurance Company of Canada.* University of Toronto, Centre for Studies of Aging.

Chirikos, T.N., & Nestel, G. (1991). Occupational Differences in the Ability of Men to Delay Retirement. *The Journal of Human Resources*, 26(1), 1-26.

Daly, M.C., & Bound, J. (1996). Worker Adaptation and Employer Accommodation Following the Onset of a Health Impairment. *Journal of Gerontology*, 51B(2), S53-S60.

Ginn, J., & Arber, S. (1995). Exploring Mid-Life women's Employment. *Sociology.* 29(1): 73-94

Goetting, M.A., Martin, P., Poon, L.W., Johnson, M.A. (1996) Economic well-being of community-dwelling centenarians. *Journal of Aging Studies.* 10(1): 43-55.

Guillemard, A.M. (1991). International Perspectives on Early Withdrawal form the Labour Force. in J. Myles and J. Quadagno (eds.), *States, Labor Markets, and the Future of Old-Age Policy*. (pp. 209-226). Philadelphia, PA: Temple University Press.

Guillemard, A.M., & Rein, M. (1993). Comparative Patterns of Retirement: Recent trends in Developed Societies. *Annual Review of Sociology*, 19(), 469-503.

Hareven, T.K., (1996). Life Course. *Encyclopedia of Gerontology.* Volume 2 pp. 31-40.

Henretta, J.C., Chan, C.G., & O'Rand, A.M. (1992). Retirement Reason Versus Retirement Process: Examining the Reasons for Retirement Typology. *Journal of Gerontology*, 47(1), S1-S7.

Jacobs, K., Kohli, M., Rein, M. (1991). Germany: The Diversity of Pathways. In M. Kohli, M. Rein, A.M. Guillemard & H van Gunsteren (Eds.), *Time For Retirement: Comparative Studies of Early Exit From the Labor Force*. (pp. 181-221). Cambridge, Massachusetts: Cambridge University Press.

Laczko, F., Dale, A., Arber, S., & Gilbert, G. N. (1988). Early Retirement in a Period of High Unemployment. *Journal of Social Policy*, 17(3), 313-333.

McDonald, L., Donahue, P. & B. Moore (1997). *Widowhood and Retirement: Women on the Margin*. IESOP Series Paper no. 17. Hamilton, Ontario: McMaster University.

McDonald, L. (1997). The Link Between Social Research and Social Policy Options: Revese Retirement as a Case in Point. *Canadian Journal on Aging/Canadian Public Policy Supplement.* 90-113.

McDonald, L. (1996). *Transitions Into Retirement: A Time for Retirement*. Toronto, ON: Centre For Applied Social Research, Faculty of Social Work, University of Toronto.

Midanik, L.T., Soghikian, K., Ransom, L.J., & Polen, M.R. (1990). Health Status, Retirement Plans, and Retirement. *Journal of Aging and Health*, 2(4), 462-474.

Mitchell, O.S., Levine, P.B., & Pozzebon, S. (1988). Retirement Differences by Industry and Occupation. *The Gerontologist*, 28(4), 545-551.

OECD. (1996). *Ageing in OECD countries: A critical policy challenge*. France: OECD.

OECD. (1995). *The Transition From Work to Retirement*. Social Policy Studies No. 16.

Ozawa, M.N., & Law, S.W. (1992). Reported Reasons for Retirement: A Study of Recently Retired Workers. *Journal of Aging and Social Policy*, 4(3/4), 35-51.

Palmore, E.B., Burchett, B.M., Fillenbaum, G.G., George, L.K., & Wallman, L.M. (1985). *Retirement: Causes and Consequences*. New York: Springer Publishing Company, Inc.

Parker, S. (1980). *Older Workers and Retirement*. London: OPCS, HMSO.

Quinn, J.F. Burkhauser, R.V. (1990). Work and Retirement. In R.H. Binstock & L.K. George (Eds.), *Handbook of Aging and the Social Sciences (3rd ed.)* New York, New York: Academic.

Reimers, C., & Honig, M. (1989). The Retirement Process in the United States: Mobility Among Full-Time Work, Partial Retirement, and Full Retirement. in W. Schmahl (ed.), *Redefining the Process of Retirement: An International Perspective*. (pp. 115-131). New York: Springer-Verlag.

Reis, M. & Puskar Gold, D. (1995). Retirement, Pesonality, and Life Satisfaction: A review and Two Models. *The Journal of Applied Gerontology.* 12(2) 261-282.

Ruhm, C.J. (1990). Determinants of the Timing of Retirement. in P.B. Doeringer (ed.), *Bridges to Retirement: Older Workers in a Changing Labor Market*. (pp. 23-32) Cornell University.

Schellenberg, G. (1994). *The Road to Retirement: Demographic and Economic Changes in the 90's*. Ottawa, ON: Canadian Council on Social Development.

Statistics Canada. (1997). *A Portrait of Seniors In Canada. Second Edition*. Ottawa: Ministry of Industry.

Statistics Canada (1995). *The 1994 General Social Surevy – cycle 9 Education, Work and Retirement. Public Use Microdata File Documentation and Users Guide.* Statistics Canada.

Villani, P.J. & Roberto, K.A. (1997) Retirement Decision-Making: Gender issues and Policy Implications, *Journal of Women and Aging.* 9(1/2) 151-163.

Wanner, R.A., McDonald, P.L. (1986). The Vertical Mosaic in Later Life: Ethnicity and Retirement in Canada. *Journal of Gerontology*. 41(5): 662-671.

Wise, D. (1993). Firms Pension Policy and Early Retirement. In A.B. Atkinson & M. Rein (Eds.), *Age, Work, and Social Security* (pp. 51-88). New York, New York: St. Martin's Press.

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